

<place patient label here>

Exam Date/Time: _____

Forensic Examiner: _____

Facility: _____

Date of Assault: _____ Time: _____ AM/PM

OSP SAFE Kit Collected: Yes No

Hours Post Assault: _____

Kit #: _____

Reporting: Yes No

Case # (if available): _____

Medically Screened (see medical record): Yes No

COLLECT ORAL SWABS IF INDICATED, then patient may have fluids

For Suspected Drug Facilitated Sexual Assault, collected blood and urine ASAP

Mandatory Reporting: See "State of Oregon Medical Guidelines for Sexual Assault Evaluation"

Serious Physical Injury or **Injury** from a Yes No

weapon (**Injury must be reported. Report of sexual assault is not mandated**).

<18 years of age or ≥ 65 years of age? Yes No

Disabled, Mentally Ill? Yes No

Agency Reported to? _____

Report made by? _____

Date/time of report? _____

Advocate? Yes No Others present at time of interview: _____

Others present at time of exam: _____

Interpreter used? Yes No Name: _____ Language: _____

I. SINCE THE TIME OF THE ASSAULT

Has the patient done any of the following since the assault?

Change clothes? Yes No

If clothing change, location: _____

Brushed teeth? Yes No

and description of clothing: _____

Used mouthwash? Yes No

Vomited? Yes No

Taken fluids? Yes No

Bathed/showered? Yes No

When was the last bath/shower? _____

Urinated? Yes No

baths/showers since assault: _____

Douched? Yes No

Tampon/pad in place since assault? Yes No

Used tampon/pad? Yes No

tampons used since assault? _____

Used enema? Yes No

Defecated? Yes No

Tampon/pad to be included in Kit? Yes No

II. REPORT OF INCIDENT – This form is to be completed by ONE examiner.

- Report is not an exhaustive account of every detail of the sexual assault. It is a brief description.
- Please recount the **patient’s own words in quotes** when possible.
- **Do not include personal opinion or conjecture.**
- Include only information that **directly relates** to this sexual assault such as a brief description of physical surroundings, threats, weapons, trauma, sexual acts demanded and performed, penetration or attempted penetration, ejaculation.
- Include patient’s descriptions of emotional states before, during and after the assault.
- Ensure that the patient understands your questions and vocabulary.
- **Record patient’s own terminology.** Do NOT sanitize language.

_____ (printed name of medical provider/nurse examiner)

_____ (signature of medical provider/nurse examiner)

_____ **DATE**

III. PERTINENT/RECENT HEALTH HISTORY

Has the patient undergone recent medical, surgical or gynecological procedures or treatment which may affect physical findings or evidence collection?

Yes No (describe) _____

Last menstrual period: _____ Patient menstruating at time of assault? Yes No

Contraception currently used: (specify if known) _____

Last consensual sexual contact? _____ Type: Oral Anal Vaginal

Is patient pregnant? Yes No # of weeks: _____

IV. INFORMATION PERTAINING TO ASSAULT

Location of assault: (address if known) _____

House/apartment, automobile, outdoors, other/unknown: (description/details of location) _____

Did patient consume drugs/alcohol prior to assault: Yes No (specify type if known) _____

Did patient consume drugs/alcohol after the assault: Yes No (specify type if known) _____

V. ASSAILANT(S) INFORMATION

TOTAL # of Assailants: _____

Assailant (a):

Name: _____ Unknown

Description: _____

Relationship to victim: _____ Age: (if known) _____

Assailant (b):

Name: _____ Unknown

Description: _____

Relationship to victim: _____ Age: (if known) _____

Assailant (c):

Name: _____ Unknown

Description: _____

Relationship to victim: _____ Age: (if known) _____

VI. ACTS DESCRIBED BY THE PATIENT

Use patient's words for penis, vagina, breast, buttocks, anus and ejaculation.

Was there penetration:

Mouth: Yes No Attempted Unknown

Vagina: Yes No Attempted Unknown

Anus: Yes No Attempted Unknown

By:

Penis Finger Tongue

Object/Other: _____

Penis Finger Tongue

Object/Other: _____

Penis Finger Tongue

Object/Other: _____

Did ejaculation occur:

Mouth: Yes No Unknown

Anus: Yes No Unknown

Vagina: Yes No Unknown

Externally: Yes No Unknown

If externally, where?

On patient's body? Where? _____ On an item/object? (specify if known) _____

During the assault did assailant(s):

Use a condom? Yes No Unknown

Use lubrication? (saliva, Vaseline, etc) Yes No Unknown (specify if known) _____

Kiss, lick, spit or make other oral contact? Yes No Unknown (specify if known) _____

Touch the patient in any other way? Yes No Unknown (specify if known) _____

Any injuries to patient? Yes No Unknown (specify if known) _____

Did patient lose consciousness? Yes No Unknown (specify if known) _____

Any injuries to assailant(s)? Yes No Unknown (specify if known) _____

Were acts performed by the patient on the assailant(s)? Yes No Unknown

Oral Copulation Masturbation Foreign Objects: _____ Other: _____

Weapons/Force Used?:

(Check all that apply per patient report/physical findings; describe the incident/body part involved.)

Verbal threats _____

Strangulation/choking* (if yes, see below) _____

Bites _____

Hitting _____

Burns _____

Gun _____

Knife _____

Blunt object _____

Restraints _____

Chemical(s) _____

Other weapon _____

Other physical force _____

(grabbed, grasped or held down) _____

***Strangulation can cause permanent damage or death if not assessed properly and immediately.**

For Reported/Suspected Strangulation Only – Please screen for the following (check all that apply):

***Strangulation can cause permanent damage or death if not assessed properly and immediately.**

- | | |
|-----------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Pain/tenderness |
| <input type="checkbox"/> Involuntary urination/defecation | <input type="checkbox"/> Swelling/edema |
| <input type="checkbox"/> Difficulty/pain swallowing | <input type="checkbox"/> Combativeness/irritability/restlessness |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Uncontrolled shaking |
| <input type="checkbox"/> Voice loss/changes | <input type="checkbox"/> Hyperventilation |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Dyspnea/apnea |
| <input type="checkbox"/> Drooling | <input type="checkbox"/> Petechiae |
| <input type="checkbox"/> Persistent throat pain | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Breathing difficulties | <input type="checkbox"/> Crepitus |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Abnormal carotid pulse |
| <input type="checkbox"/> Headache | |

Estimated length of time strangulation occurred: _____

Number of times patient was strangled during incident: _____

Number of different methods used for strangulation during incident: _____

Method(s) of strangulation: _____

Description of strangulation event(s): _____

Checklist:

- Examine scalp, eyelids, conjunctiva, chin, jaw, shoulders and chest Safety Plan
 Abuse Assessment Consider admission for observation

For Reported/Suspected Drug Facilitated Sexual Assault:

Consider collecting **blood** for **alcohol** testing and **urine** for **drug** testing as soon as possible when:

- _____ Patient appears impaired, intoxicated, or has altered mental status
_____ Patient reports blackout, memory lapse, or partial or total amnesia for event
_____ Patient or other is concerned that he or she may have been drugged

Suspected Substances: _____

Blood Collected? Yes No Urine Collected? Yes No

Drug and alcohol testing may be done for legal purposes. Legal specimens follow a chain of custody and are given to law enforcement not sent to the lab.

Separate consents for toxicology specimens need not be obtained, but patient should be informed that specimens are obtained.

VII. MEDICAL FORENSIC EXAM (FEMALE)

Affect assessment (describe behavior-awake, alert, sleeping, flat, quiet, crying, etc.): _____

Physical examination (check if normal, describe if abnormal):

- | | | | |
|---------------------------------|-------|-------------------------------------|-------|
| <input type="checkbox"/> Neuro | _____ | <input type="checkbox"/> Chest | _____ |
| <input type="checkbox"/> Head | _____ | <input type="checkbox"/> Breast | _____ |
| <input type="checkbox"/> Eyes | _____ | <input type="checkbox"/> Abdomen | _____ |
| <input type="checkbox"/> Ears | _____ | <input type="checkbox"/> Back | _____ |
| <input type="checkbox"/> Nose | _____ | <input type="checkbox"/> Neck | _____ |
| <input type="checkbox"/> Throat | _____ | <input type="checkbox"/> Upper Ext. | _____ |
| <input type="checkbox"/> Mouth | _____ | <input type="checkbox"/> Lower Ext. | _____ |

Was lubricant used for exam: Yes No If yes, type: _____

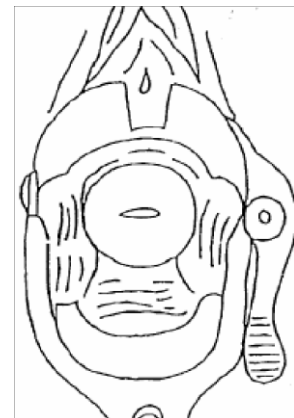
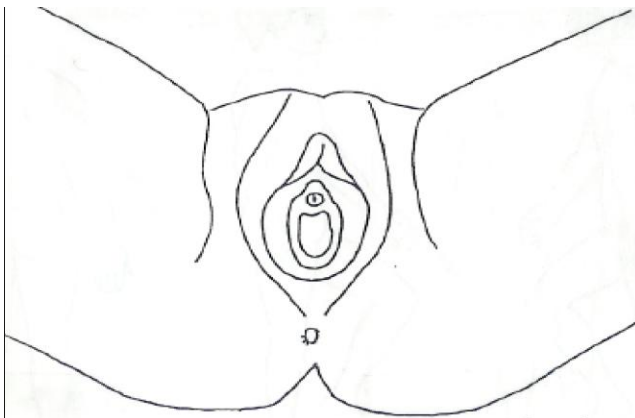
Female

WNL

Describe (use diagram for injuries and note here – if not done, note not done.)

I. II. III. IV. V.

- | | | |
|------------------------|--------------------------|----------------------|
| Tanner Stage | <input type="checkbox"/> | _____ |
| Mons Pubis | <input type="checkbox"/> | _____ |
| Clitoral hood/clitoris | <input type="checkbox"/> | _____ |
| Labia majora | <input type="checkbox"/> | _____ |
| Labia minora | <input type="checkbox"/> | _____ |
| Urethral meatus | <input type="checkbox"/> | _____ |
| Posterior fourchette | <input type="checkbox"/> | _____ |
| Fossa navicularis | <input type="checkbox"/> | _____ |
| Vaginal opening | <input type="checkbox"/> | _____ |
| Hymen | <input type="checkbox"/> | _____ |
| Vagina | <input type="checkbox"/> | _____ |
| Cervix | <input type="checkbox"/> | _____ |
| Perianal skin | <input type="checkbox"/> | _____ |
| Anus | <input type="checkbox"/> | _____ |
| Buttocks | <input type="checkbox"/> | _____ |
| Anoscope/rectum | <input type="checkbox"/> | _____ (if indicated) |



VIII. MEDICAL FORENSIC EXAM (MALE)

Affect assessment (describe behavior-awake, alert, sleeping, flat, quiet, crying, etc.):

Physical examination (check if normal, describe if abnormal):

<input type="checkbox"/> Neuro	_____	<input type="checkbox"/> Chest	_____
<input type="checkbox"/> Head	_____	<input type="checkbox"/> Breast	_____
<input type="checkbox"/> Eyes	_____	<input type="checkbox"/> Abdomen	_____
<input type="checkbox"/> Ears	_____	<input type="checkbox"/> Back	_____
<input type="checkbox"/> Nose	_____	<input type="checkbox"/> Neck	_____
<input type="checkbox"/> Throat	_____	<input type="checkbox"/> Upper Ext.	_____
<input type="checkbox"/> Mouth	_____	<input type="checkbox"/> Lower Ext.	_____

Circumcised: Yes No

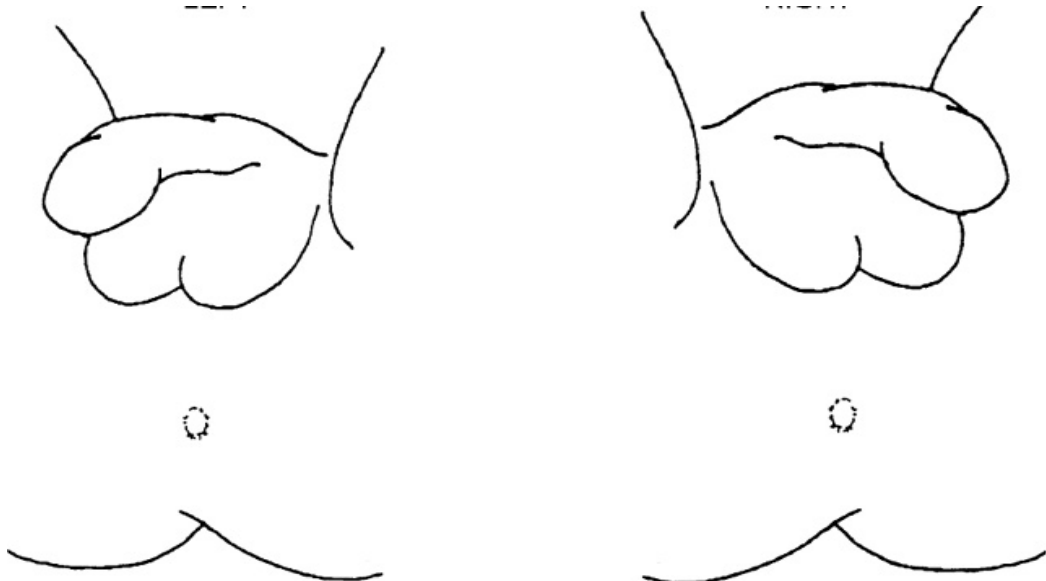
Male

- Tanner Stage
- Foreskin
- Glans penis
- Penile Shaft
- Urethral meatus
- Scrotum
- Testes
- Perineum
- Rectum
- Anus
- Perianal skin
- Buttocks
- Anoscope/rectum
- Other

WNL

Describe (use diagram for injuries and note here – if not done, note not done.)

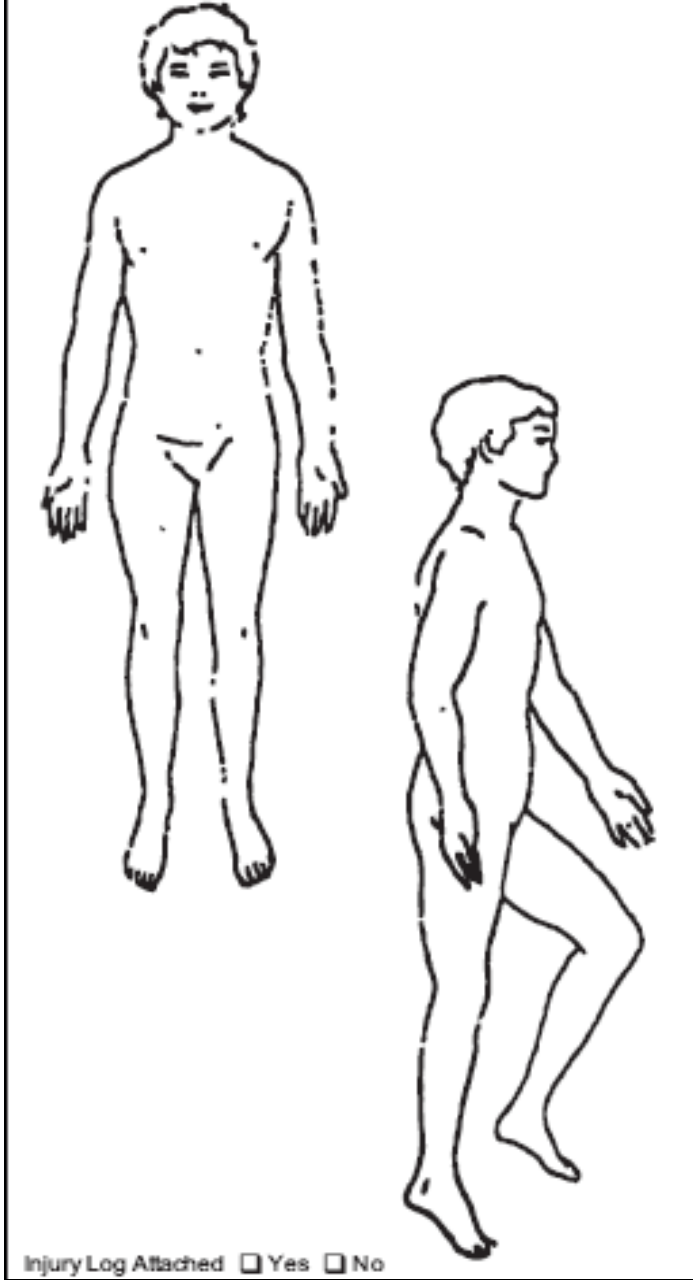
I. II. III. IV. V.



IX. ADULT BODYGRAM

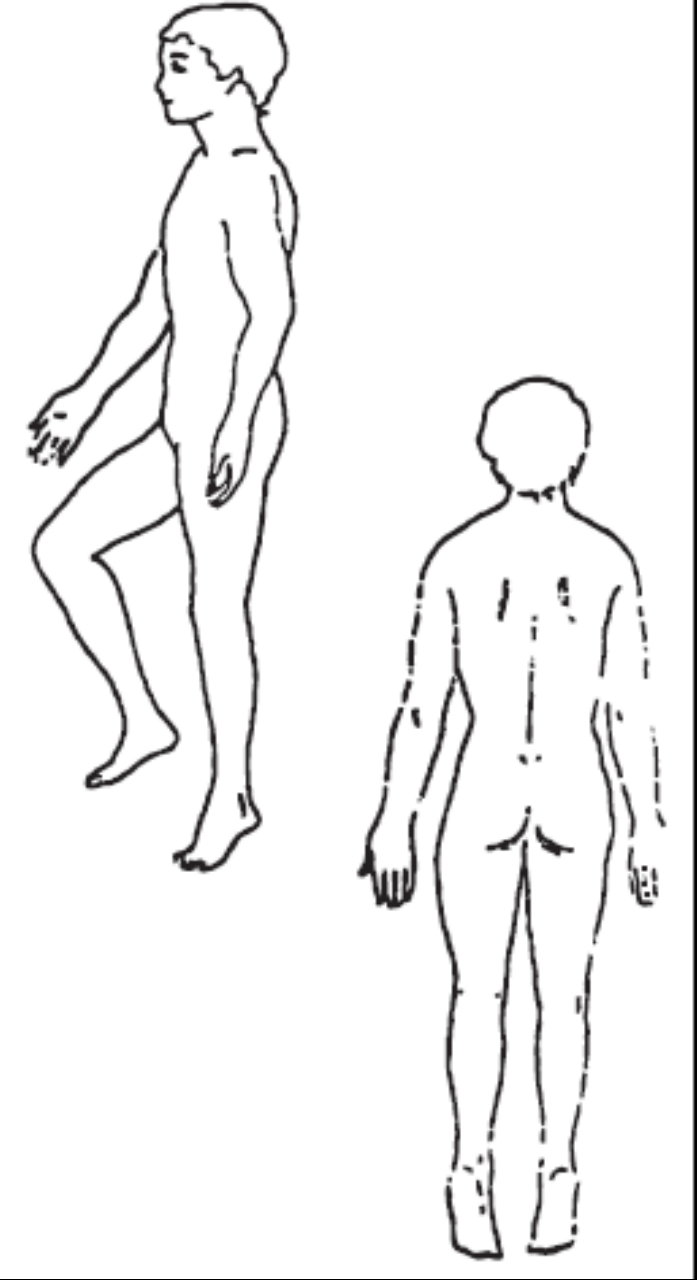
Diagram Key (shade tender areas) A = Abrasion AL = Alternate Light Source B = Bruising BI = Bite BU = Burn
CN = Contusion FB = Foreign body/debris KW = Knife Wound LA = Laceration PE = Petechiae R = Redness
S = Swelling SHX = Sample per history SI = Suction Injury T = Tear TE = Tenderness OI = Other Injury

DIAGRAM A:



Injury Log Attached Yes No

DIAGRAM B:



X. ADULT BODYGRAM

Diagram Key (shade tender areas)

CN = Contusion FB = Foreign body/debris KW = Knife Wound LA = Laceration PE = Petechiae R = Redness
S = Swelling SHX = Sample per history SI = Suction Injury T = Tear TE = Tenderness OI = Other Injury

A = Abrasion AL = Alternate Light Source B = Bruising BI = Bite BU = Burn

DIAGRAM C:



DIAGRAM D:



DIAGRAM E:

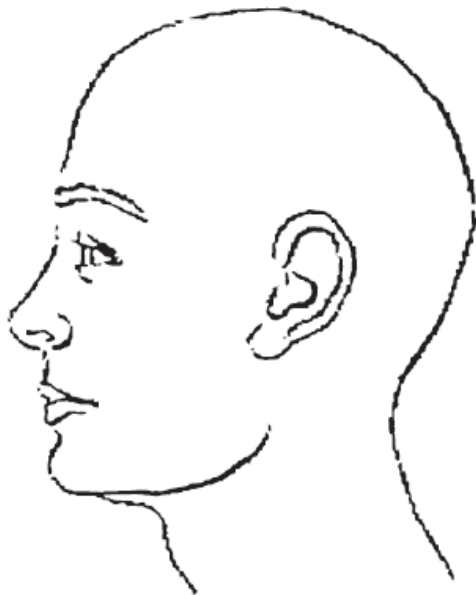
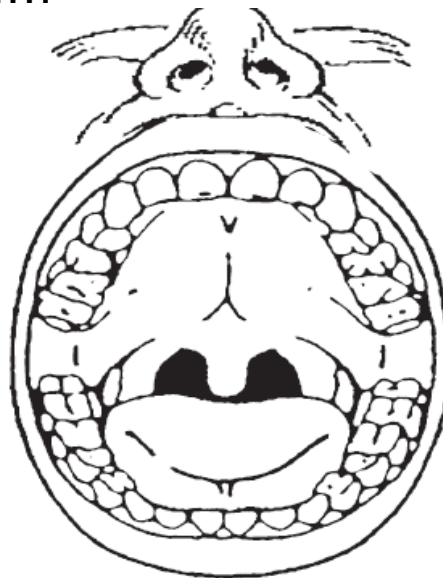


DIAGRAM F:



XI. INJURY LOG

Use injury log in conjunction with body map to document type, size, shape and color of injuries.

Injury #	Diagram #	Key Code	Photos Taken	Description

XII. EVIDENCE COLLECTION

(Follow SAFE kit guidelines. Clearly identify, date, initial and seal all containers.) Check specimens obtained.

A. Clothing worn at time of assault: Obtained Not Obtained N/A

- Have patient undress on large paper sheet.
- Bag clothing individually in paper bags.
- Paper sheet should be folded and placed in paper bag/
- All bags should be sealed and labeled with patient name, date, time and your initials.

List articles of clothing:

_____	_____
_____	_____
_____	_____

B. Hair Obtained Not Obtained N/A

- Pull or comb 24-30 hairs from various areas of head.
- Place in envelope.
- Seal and label envelope

C. Oral Swabs (collect 4): Obtained Not Obtained N/A

- Swab the inner cheek and gum line of mouth with 4 sterile swabs.
- Dry swabs and place in envelope.
- Seal and label envelope.
- Label purpose of collection (seminal fluid/DNA standard).

D. Alternate Light Source (Blue Maxx if available) Examination: Obtained Not Obtained N/A

Fluoresced: Positive Negative
Swabs Obtained: Yes No

- Use an alternate light source to examine skin and hair for possible seminal fluid or other body fluids.
- If area fluoresces, collect the sample with water moistened swab(s).
- Place in appropriate envelope.
- Seal and label envelope.

E. If bite marks are present: Obtained Not Obtained N/A

Site(s) swab taken: _____

- Apply water moistened swab to suspected area to obtain assailant's saliva.
- The neck and breasts of females and the back and shoulders of males may be additional sites and should be swabbed, especially if reddening appears in these areas.
- Dry swab and place in envelope.
- Seal and label envelope.

Cleanse bite or scratch marks. Done Not Done N/A

F. Pubic Hair Combing: Obtained Not Obtained N/A

- Comb pubic area and place comb, loose hair and any foreign debris in envelope.
- Seal and label envelope.

G. Vaginal Swabs: Obtained Not Obtained N/A

- Saturate 4 swabs in vaginal fluid, 2 at a time.
- Smear 1 glass slide.
- Dry swabs and slide and place in envelope/slide holder.
- Seal and label envelope/slide holder.

H. Cervical Swabs:

Obtained Not Obtained N/A

- Swab the cervix with 4 sterile cotton swabs, 2 at a time.
- Smear 1 glass slide.
- Dry swabs and slide and place in envelope/slide holder.
- Seal and label envelope/slide holder.

I. For Rectal Sodomy:

Obtained Not Obtained N/A

- Collect 4 rectal swabs, 2 at a time.
- Smear on 1 glass slide.
- Dry swabs and slide and place in envelope/slide holder.
- Seal and label envelope/slide holder.

J. Additional Evidence:

Obtained Not Obtained N/A

- Site(s): _____
- Site(s): _____
- Site(s): _____
- Site(s): _____
- Site(s): _____
- Site(s): _____
- Site(s): _____
- Site(s): _____
- Site(s): _____

K. Photographs:

Obtained Not Obtained N/A

- Taken by Whom: _____
- Camera/equipment used: _____
- See bodygram for photographs taken

XIII. POLICE DEPARTMENT RECEIPT OF PERSONAL BELONGINGS AND SPECIMENS

This is to certify that on _____ (date) at _____ (time) personal belongings and/or specimens were:

- locked in evidence locker per facility protocol or
- hand delivered to law enforcement

_____	_____	_____
(printed name of receiving agency)	(Signature and title of receiving agency)	Date
_____	_____	_____
(RN signature)	(SANE #)	Date

***Include copies of pages 1 – 12 in the SAFE Kit.**

XIV. HIV RISK ASSESSMENT FOR Post-exposure Prophylaxis (Discuss with Physician if "yes")

- a. Vaginal or anal penetration Yes No Unknown
- b. Ejaculation occurred on mucous membranes Yes No Unknown
- c. Multiple Assailants Yes No Unknown
- d. Mucosal lesions present in patient Yes No Unknown
- e. Drug use by assailant (IV crack, cocaine, etc.) Yes No Unknown
- f. Assailant having multiple sexual partners Yes No Unknown
- g. Male assailant having sex with other males Yes No Unknown
- h. Sex industry/human trafficking Yes No Unknown

(describe)

***See HIV Algorithm for a more complete assessment**

XV. TREATMENT

- | | YES | NO | |
|------------------------------------|--------------------------|--------------------------|-------|
| a. STI Prophylaxis | | | |
| - Chlamydia prophylaxis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| - Gonorrhea prophylaxis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| - BV/trichomonas prophylaxis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b. Negative Pregnancy Test | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c. Emergency Contraception offered | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| d. Tetanus immunization | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| e. Hepatitis B. Vaccine | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| f. HIV nPEP | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| g. Other Medications | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

XVI. FOLLOW UP AND REFERRALS

- | | YES | NO | |
|-------------------------------|--------------------------|--------------------------|---------------------|
| a. Referral packet given | <input type="checkbox"/> | <input type="checkbox"/> | |
| b. Counseling/social worker | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. Crisis intervention agency | <input type="checkbox"/> | <input type="checkbox"/> | Agency: _____ |
| d. Practitioner follow-up | <input type="checkbox"/> | <input type="checkbox"/> | What service? _____ |

***DO NOT Include this Page in SAFE Kit.**